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THE RORSCHACH TEST: A CLINICAL EVALUATION*

BY DAVID RAPAPORT AND ROY SCHAFER

The present need for good clinical-psychological tests warrants an attempt to re-evaluate those tests we have come to lean upon heavily in our everyday work. The Rorschach Test is a prominent one of these and in this paper we shall discuss it in terms of: (a) the place it has, according to our experience, in clinical work; (b) the attitudes and procedures which make it an effective tool; and (c) the need for extensions of this test. We shall take it for granted that the reader is familiar with the test, and we shall forego a description of its material, administration and diagnostic analysis.

(a) THE PLACE OF THE TEST IN CLINICAL WORK

The use of the Rorschach Test, as one in a battery of tests, in a clinical-psychiatric setting for purposes of diagnosis and appraisal of adjustment, shows: (1) that it is beyond doubt the most potent single diagnostic instrument clinical psychology possesses; (2) that as an exclusive basis of diagnosis the test has serious limitations and its real potency is exploited only when used as the center of a battery of tests; (3) that the literature on the test is one-sided, lacking reports on limitations of the test; (4) that the test can be used as a simple tool and skill in handling it may be easily acquired, although its efficient use requires psychological and clinical knowledge, understanding and versatility.

(1) Notwithstanding the reports of unsuccessful mass evaluations and failures of applications to screening and leadership selection, the clinical validity of the test has been proved in our experience and is amenable to statistical validation.[1]

(2) The test has a welter of variables, all of which may occur in adjustments and in maladjustments of different types and degrees of severity (neuroses, psychoses, character disorders, addictions, organic lesions of the central nervous system and psychosomatic disorders). In many cases the test has indications to show in what setting a certain sign occurs, e.g.,

* For the appraisal of intelligence testing, concept formation testing and phantasy testing see Bulletin of the Menninger Clinic, Vol. 7, No. 3, May 1943; see also Rapaport, Gill and Schafer[1].

whether an increased ideational productivity refers to creative ingeniousness or is in a setting in which it must be considered indicative of intensive phantasying, phobias, obsessions, delusions, or confusion, etc. In other cases the meaning of increased ideational activity indicated by the test can only be established from evidence derived from other tests.

(3) In many cases extreme impairment or extreme wealth of the total record, or of one aspect of it, makes it altogether difficult to derive even a gross diagnosis from it. In inhibited or depressive cases the records are often so empty as to give little understanding of the person who is suffering the condition and the widespread, extreme impairment hides the indications for one of the many hundred variants of the condition. Transient psychotic breaks in compulsive personalities (e.g., paranoid conditions), addictions and other nosological entities are rarely diagnosed by this test alone, though they may be diagnosed in the majority of the cases from the comparison of it with a series of tests. The failure of the literature to warn the novitiate regarding these limitations might in the long run discredit the test.

(4) The test as described by Rorschach is a simple tool. Its "refinements" are, however, likely to conceal this fact. Rorschach's procedure records *only* the patient's spontaneous responses, inquires *only* into unclarities of these, and scores *only* the outstanding salient features of these. It is a quick, simple procedure and easily learned. Because of this simplicity the tests once given can be easily remembered by the examiner, this remembering being the greatest treasure and lead of the diagnostician. Not refinements of the test, but rather a *better psychological* and *clinical training* and *extensive experience with the test* will make for greater diagnostic efficiency.

Rorschach's original volume is extant in English[2] and there is no justification for omitting a study and appropriation of the simplicity of his procedure. The more recent literature may make one more sensitive to qualitative features of the test, but the simplicity of the test must not be lost sight of. An increased number of scores tempts people to translate scores of a record into standard textbook phrases and to consider the aggregate of these phrases a diagnosis—instead of trying to understand what processes took place in the patient in the course of the test, and to infer from this what the patient is like.

(b) ATTITUDES AND PROCEDURES

If one wants to use the test, along with other tests, it proves to be an economical, quick and fruitful procedure. "Refinements" were, however, introduced to make the test a self-sufficient diagnostic procedure. These refinements necessitate inquiring into *all* responses; they give rise to

additional responses; they "test limits". Quite aside from the problem of whether spontaneous responses and those obtained under pressure of inquiry are altogether comparable, these procedures take time and make the test cumbersome and hard to remember. In addition, these new procedures tend to make the worker think that the test contains more than it does and that he has to improve on the material by quizzing the patient more and more. The fact is, however, that the test-record will yield most if it is kept simple and viewed with a good psychological and clinical background.

Therefore, these are the attitudes we have found necessary for the economic and fruitful use of the test:

(1) Inquire as little as possible; be guided by the rule that questions should be asked only when the patient has not told enough by his spontaneous response to make the complete scoring possible, or where the patient has said something the examiner does not understand.

(2) If the inquiry is inconclusive, consider this characteristic of the patient and do not waste time inquiring further; this will lead only to more uncertainty.

(3) Keep the test record homogeneous: try to limit the material to the *spontaneous reactions* of the patient to the blots—and avoid letting him speculate and reflect (i.e., inquire with the card concealed). We can all conjecture, and become aware of many things we do not spontaneously feel and see. What the spontaneous reactions on this test do not give you, other tests will. Although the examiner may be able to deduce something from the subject's speculations, the chances are that he will lose his simple frame of reference for the test by listening to speculation; the time invested in such inquiry would be more profitably spent in giving other tests to compare and integrate with the Rorschach Test.

(4) Strive for such a clear understanding of the test that you can score the patient's responses as you record them. This makes one alert to the points where he must inquire.

(5) Inquire and score carefully, and prepare the formal psychogram—but do not forget that the scores reflect merely, in convenient and intra- as well as inter-personally comparable form, what should be apparent to you in the responses. Therefore concentrate on the understanding of the perceptual development as well as the associative elaboration of the responses, because it is the mode and degree of cogwheeling of these two which is characteristic for the individual subject or patient. Responses are born in the interplay of progressive perceptual reorganization of the blot and of the progressive associative elaboration of it, these normally proceeding to the point where the two are assimilated to each other. The degree of sufficiency of the assimilation as well as the wealth or poverty of

the final product are characteristic for the individual. The scores merely reflect different aspects of this assimilation process.

(c) EXTENSIONS OF THE TEST

Our experience shows, that the fewer extensions made in the scoring system, the better the test fits into a clinical setting by virtue of its economy of administration, its easy surveyability, and its being easily remembered for future reference of the diagnostician. Our experience shows that most of the extensions proposed since the Binder shading study[3] were for the most part insufficiently validated with respect to their diagnostic *meaning*. They were born partly of an undue optimism that this amazingly powerful clinical tool could encompass the total complexity of personality. Such expectations, however, are but fruits of wishful thinking. Therefore we *must* demand much more stringent demonstrations of any extension than we have thus far for the existing scoring system.

There is, however, one respect in which recent clinical trend demands extension—not of scores but rather of intensity of attention and clarity of thinking. In recent papers by Lindner[4] and Bergmann* attention is called to particular types of *verbalization* of responses. This aspect of the test has been little exploited and yet work with schizophrenias, paranoid psychoses and conditions prodromal to psychosis, forces one to pay considerable attention to these. The fabulation, confabulation, contamination concepts of Rorschach begin to touch on this associative-verbalization aspect of the responses. Experience shows that there are many nuances of verbalization encountered in the records, attention to which often proves diagnostically crucial—especially in psychoses with well prserved "fronts" and in differentiating conditions prodomal to schizophrenia from schizophrenia proper. The investigation of these also seems to shed light on important aspects of the psychology of thinking as well as upon the nature of the schizophrenic thought disorder.[1] A broad and as yet almost unentered field of exploration is open in this aspect of the test, which offers the possibility for more intensive analysis. This, however, should not be one which complicates the test and makes it forbidding for the "uninitiated," but rather one which offers to him an additional avenue of understanding the test.

CONCLUSIONS

(1) The Rorschach Test is the most efficient single diagnostic tool we possess.

(2) As presented in Rorschach's *Psychodiagnostics* it is an easily learned technique.

* See page 78 of this issue.

(3) Its proficient use hinges on the examiner's clinical-psychological and psychiatric knowledge.

(4) Its most proficient application accrues from its use as a central test *in a battery* of tests.

(5) Extensions and "refinements" of the test tend to make it cumbersome time-consuming and prohibitive for clinical use. Therefore extensions, unless excellently documented as valid and indispensable, should be avoided.

(6) Attention is called to the diagnostic significance of the verbalization of responses.

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HOMOSEXUALITY ON THE RORSCHACH TEST*

By Sgt. MARTIN S. BERGMANN†

Homosexuality is surrounded by so many cultural prohibitions and individual inhibitions that many a victim of it finds it difficult to disclose his affliction, even to the psychiatrist whose assistance he may seek. Army psychiatrists are confronted with an added difficulty; they must overcome not only the common reluctance of the homosexual to face exposure, but a new fear arising out of the conditions of Army life: the dread of military punishment.

It is often assumed that the Army is a homosexual's paradise. In reality the opposite is true. On the one hand the masculine society of the barracks and the close physical contacts in boxing, wrestling and other Army routines offer an excessive stimulus to the homosexual. On the other hand, he realizes that any attempt to satisfy his aroused senses would be fraught with more danger than similar overtures in civilian life. The very communal aspect of this new world is a threat; someone may report him. He is stalked by the specters of court martial, imprisonment, dishonorable discharge.

Particularly acute in the Army is the problem of the married homosexual. Some of these men have struggled over a long period to achieve a sexual adjustment of sorts, and have arrived, through marriage, at a precarious balance between homosexual and heterosexual gratification. Induction with separation from their wives evokes the fear that the efforts of all those years have been wasted.

Under the stress of such conflicts, neurotic tendencies are exacerbated and tensions increase. The homosexual may manifest anxiety states or depression, belligerence or symptoms of conversion hysteria. If the conflict takes the form of anxiety, the soldier as a rule will go to the chaplain and "confess". If it takes the form of conversion symptoms, he may seek medical help for "headaches", "back pains", "gastric disturbances", etc. In either case he is likely to be referred to the psychiatrist.

When a soldier comes to the psychiatrist claiming to be a homosexual, the interviewer must determine whether he is dealing with a genuine, chronic homosexual, or as occasionally, with a man simulating homosexuality in order to obtain a discharge from the Army.

Where the homosexual is hiding behind a conversion symptom, the psychiatrist's problem is somewhat different. Such a man usually arrives

* The author is indebted to Major Geo. S. Goldman, M.C., I.R.T.C. Psychiatrist at Camp Wheeler, Ga., for his encouragement and valuable suggestions in this work.

† Psychiatric Consultation Service, Fort Lewis, Washington.

at the office with the intention of discussing physical symptoms only. Any other information must be drawn from him indirectly. During the interview, the psychiatrist may perceive suggestions of homosexuality: over-dependence on the mother, a conscious or unconscious dread of sexual matters, a curiously empty sexual history devoid of any emotional attachments. Notwithstanding such clues, he has no tangible proof that his hunch is correct. Clinical procedures which could be helpful in these instances are not available.

At the Psychiatric Consultation Service in Camp Wheeler, Georgia, we have found that the Rorschach Test is a useful aid in such situations. We have observed that homosexuals taking the Rorschach Test, give responses that differ from those of non-homosexuals.

In Rorschach literature no study has appeared which deals with the responses of homosexuals. In order to determine whether or not the test differentiates them, we gave Rorschach tests to 20 soldiers whose homosexuality had been clinically established.

The sample group was a heterogenous one. The men had come to the Army from occupations as varied as farming, photography, journalism, college, clerical work and manual labor. Nineteen of them were white, one was Negro. All but two were American born. Ages ranged from 18 to 36 years, with 24 as the average. Intelligence, insofar as it can be measured by the Army General Classification Test, varied from 60 (equivalent to a mental age of 9) to 130, with 101.2 as the average. Nine of the men had been diagnosed as psychopaths and offenses other than homosexuality, such as insubordination, AWOL and previous prison records, were numerous. Seven of the subjects were married.

Of the 20 tested, 15 had come to the psychiatrist at their own request. Only five had been referred by the authorities for psychiatric diagnosis in connection with disciplinary action. Since all the men were aware, before taking the test, that the interviewer recognized them as homosexuals, much of the anxiety about "detection" was absent.

One striking quantitative difference was found between the responses of these men and the responses of non-homosexuals. The sample group gave a high percentage of responses of sexual content. 21.7% of their responses were of this type (see Table I). The most unsophisticated of the men saw a penis in every elongation and a vagina in every opening. Frequently, also, they selected sexual organs from the tiny edges of the cards, as if they did not quite dare to "go into" the card itself. The excessive number of such responses appears to reflect the specific sexual anxiety of the homosexual. In Rorschach literature, anatomy responses are considered to be indicative of anxious preoccupation with the self. Some of the men were so monotonously consistent in this as to reveal dullness of both emotions and intellect.

Significant, too, was the manner in which these images were seen. Sex organs were perceived in action, frequently associated with blood, eruptions, or inanimate movements such as dripping. It is characteristic that the homosexual should give responses of this nature, since m,CF images are usually considered as indicative of inner tension. One man saw the upper half of Card VI as a penis, and the gray shading at the side as "the semen splashing." Another perceived Card IX as "a male sex organ exploding into a female organ," the red connoting the explosion. These responses suggest fantasies often encountered by psychoanalysts, in which sexual intercourse has sadistic connotations, and the penis is felt to be a wounding

TABLE I

AVERAGE DISTRIBUTION OF RORSCHACH SCORES (IN TERMS OF PERCENTAGES) IN A SAMPLE OF 20 HOMOSEXUALS

Determinants		Location	
Average number of responses	15.9	W (whole) responses	31.0
F (form) responses	56.9	D (large detail) responses	48.0
M (human movement) responses	9.7	d (small detail) responses	18.0
FM (animal movement) responses	17.3	S (white space) responses	2.0
m (inanimate movement) responses	2.8	DW (confabulation) responses	1.0
FC (color) responses	3.2		
CF (color) responses	3.4	Contents	
C (color) responses	2.2		
C̆ (achromatic) responses	.7	A (animal) responses	22.7
Fc (shading) responses	1.1	animal detail responses	8.8
K (diffusion) responses	.7	human responses	8.8
FK (vista) responses	1.2	human detail responses	6.0
		anatomy responses	6.3
		sexual responses	21.7
		fire and blood responses	4.5
		other content responses	20.7

instrument of exaggerated potency. Such fantasies play a significant role in the blocking of heterosexual intercourse.

The three confabulations listed in Table I also occurred in sexual responses. Card I and Card IX were seen as naked girls, although the testee could point out nothing more distinct than their "brassieres."

Figure and ground relationships were, here and there, reversed. Some of the men perceived sex organs in the white spaces, even in those on the edges of the ink blots. Cards VIII and IX seemed partioularly to invite the latter reaction. This was interesting inasmuch as white space responses are usually interpreted in the Rorschach literature as reflecting tendencies of "opposition" and "negativism".

A second striking reflection of homosexuality was revealed in the unique

way our sample group handled human movement (M) responses. In Rorschach interpretation of records of normal subjects, M responses generally indicate creativity and the capacity to sublimate basic drives. Furrer and recently Beck have pointed out, that the M's often communicate "the innermost personal needs of the individual". It is significant that in these responses contents suggestive of homosexuality were most clearly indicated. (Spontaneous human movements are rarely given by people of average or mediocre intelligence. Our records showed an average of 4.7 human movements per test. In 8 of the 20 records, these were absent, however.)

We found five typical ways in which homosexuals handled human movements.

1. Responses denoting homosexual arousal

The tendency here was to see human movement responses deviant from the usual ones, and suggestive of homosexual preoccupations. Card IV which is usually seen as a cossack or a gorilla, was described by one of our testees as the front view of a man with legs apart, head tucked between his knees, buttocks pointing upward. The movement of the entire human figure was built around the buttocks. In another instance, the orange portion of Card IX was interpreted as three men touching each other with their buttocks.

2. Responses indicating heterosexual revulsion

Here, instead of bold sexual imagery, the subjects manifested disdain of the sexual. Card V was described by one man as "a ballerina beautifully and expensively dressed, outwardly respectable and charming but inwardly repulsive." Or, in another record, the middle brown part of Card IX was seen as "huge repulsive breasts covered with the most exquisite delicate brown silk." The unconscious disgust, the revulsion against the feminine body, seeps through these images, despite the effort to "dress" the response up as a normal one.

3. *Uncertainty in the identification of men and women*

Most arresting and most consistent in the homosexuals' treatment of the M's, was the doubt exhibited as to the sex of a human figure seen. The testees showed a tendency to perceive "persons", "people", "savages", "natives", "dancers" . . . *but not men or women.* Some were quite ready to describe in detail what the "people" were doing, even the manner in which they were dressed. But the sex of the figures was glossed over. The examiner's inquiry, "Are these men or women?" usually produced a hesitation, a slight panic, followed by elaborate explanations of why the sex could not be identified positively.

One homosexual who had been trying vainly to determine the sex of a human figure, suddenly interrupted the painful search with the cry "That's just my trouble! I can't tell a man from a woman!"

The non-homosexual, taking the Rorschach, will tend to see human figures most readily in Cards II and III. We found these to be the cards most difficult for our sample group to handle. The explanation may lie in the fact that a choice does exist, normally, between selection of the human figure as a man or a woman in II and III. In Card II the figure is usually seen as wearing a heavy coat, which might be either a man's or a woman's. Similarly, in Card III, the penis-like protrusion suggests the masculine, while the "breast" and "high heels" can be indicative of the feminine.

The man to whom sexuality is not a problem, can make a choice of the sex of a human figure without difficulty. The homosexual, suffering from disturbances in the sexual sphere creates a problem where none exists normally. He wants to be careful, to make certain that he will not be caught in a mistake. The longer he hesitates, and the more cautious he attempts to be in evaluating the evidence, the more clearly is his difficulty revealed.

One soldier saw the green spot at the top of Card X as a "diver getting ready to jump." When the examiner asked whether the diver was a man or a woman, the testee replied, "the long green bathing suit makes it look like a woman." Then, dropping the card and taking it up again, he declared, "I guess it's a man. Look at the knee. It's so masculine." A non-homosexual would have been unlikely to make such farfetched and in a way exaggeratedly careful observation. Another of the men revealed similar hesitation in a response where he perceived "lips" of a full and sensuous outline, yet could not decide whether they were masculine or feminine.

4. *Responses in which both sexes were seen on symmetrical sides of the Card*

Indecision was here resolved by a tendency to see two symmetrically identical figures of a card, as one being a woman and the other a man. One soldier saw Card II as a "man and woman dancing." Queried by the examiner, who wished to know why one side resembled a woman, the soldier became puzzled and uneasy. He replied without visible logic, "The folds of flesh on the left side make me think of a woman."

RECAPITULATION

Rorschach tests were given to 20 male homosexuals of military age, whose homosexuality had been established in advance.

The specific characteristics of their responses were: (a) a high percentage of sex responses; (2) sex responses associated with anxiety and tension

(m,CF) and opposition responses (S); (3) human movement responses implying homosexually arousing content. (4) M responses indicating revulsion against the heterosexual; (5) reluctance to distinguish positively between male and female figures; (6) tendency to see one of each sex in symmetrical figures of the cards.

DISCUSSION

Two problems suggest themselves for consideration.

1. How reliable are the foregoing signs as detectors of homosexuality; that is, how frequently did they occur in the sample? Table II presents our findings.

The rate of frequency of these signs seems low. But it must be remembered that here, as in the Rorschach Test in general, even the presence

TABLE II

FREQUENCY OF TYPICALLY HOMOSEXUAL RESPONSES IN 20 RECORDS

Sex organ responses associated with anxiety signs	14 out of 20
Human movement responses with sexual or homosexual connotations	4 out of 20
Human movement responses indicating aversion to the sexual	2 out of 20
Human movement responses indicating difficulty in identifying the sex of a figure	6 out of 20
Human movement responses where male and female figures were seen in symmetrical halves of the cards	4 out of 20

of one clear sign can be highly significant. Of the 20 homosexuals tested, only five failed to show any of these responses, or gave them in very small quantities. In the remainder of the records, the signs were frequently so conspicuous that a diagnosis of homosexuality would have been possible on the basis of the Rorschach alone.

2. Are these signs encountered among non-homosexuals? Our experience at Camp Wheeler has shown that sex organ responses in percentages of total content of more than 30–40% are rare in the general population, but they do occur in neuroses, the presenting problem of which is a sexual one; for example, in cases of syphilidophobia or excessive masturbatory guilt.

Indecision in identifying the male and female figure was encountered outside the homosexual group only among psychotics.

Most significant, and requiring further elucidation is the fact that all these homosexual signs occur in psychotic records.

The Rorschach Test cannot be used as an infallible instrument for the detection of homosexuality. However, our findings suggest that it could be of practical value to Army psychiatrists who may be confronted either with simulators or soldiers accused of homosexuality which they deny.

CLINICAL EVALUATION OF A WORD ASSOCIATION TEST*

By ROY SCHAFER

The present need for simple yet effective clinical-diagnostic testing procedures to be used in a battery of tests prompts us to review the clinical experience we have had with a word association test.† In recent years the clinical application and evaluation of word association tests has become more and more neglected. The hope stemming from the results published by Jung[2], who was the first to use such a test, that significant content of the subject's conflicts would be made clear by his choice of reaction words, has not been fulfilled.‡ The aim of this paper is to indicate the broad outlines of our experience with a word association test, experience which has convincingly demonstrated that for clinical-diagnostic testing and for investigation of thought processes in general the word association test is an invaluable and yet simple tool. However the worth of such a test becomes clear only when emphasis in evaluation of results shifts away from the "content" of the reaction words or of the stimulus words and rests on an analysis of the formal relationships between stimulus words and reaction words. This emphasis on relationships makes the subject's choice of reaction words into an indicator of the organization or disorganization of associative processes characteristic of his adjustment or maladjustment.

We were driven by experience to this method of analysis and made aware of its potentialities partly by the nature of the word list we inherited and by the set of instructions devised for this test. The subject is told at the beginning of the test: "I am going to call out a list of words to you one at a time. After you hear each word I want you to tell me one other word; it doesn't matter what the word is that you tell me, but it must be the first word that comes into your mind and you must do it as quickly as possible." Thus a demand is made for speedy, unselected one-word responses. Such instructions place an especial strain on the subject's thought processes which

* The concepts and findings presented in this paper have been drawn from a detailed investigation which is reported in Volume II of *Diagnostic Psychological Testing* by Rapaport, Gill and Schafer. Chicago, Yearbook Publishing Co., 1945.

† world, love, father, hat, breast, curtains, trunk, drink, party, bowel movement, book, lamp, rug, chair, boy friend, penis, dark, depressed, spring, bowl, suicide, mountain, house, paper, homosexual, radiator, girl friend, screen, masturbate, frame, man, orgasm, movies, cut, laugh, bite, women, dance, dog, daughter, taxi, mother, table, beef, nipple, race, water, suck, horse, fire, vagina, farm, social, son, taxes, tobacco, intercourse, hospital, doctor, city: list developed by W. Orbison.

‡ Studies by Luria[3] and Huston-Shakow-Erickson[1] have indicated that there are other avenues (physiological: cerebrospinal and autonomic) of expression of disturbances elicited by stimulus words than that on the verbal level.

catalyzes the manifestation of thinking disturbances. It appears, however, that normal subjects not only behave as though they assume that their reactions must have some conventional relationship to the stimulus words, but automatically bring to mind mainly words meeting this criterion. As a result, from normal subjects one will obtain a preponderance of responses which are so frequently given by other members of the normal population that they may be considered "popular" reactions. In other words the *anticipation* that one must "make sense"* and an apparent automatic action of conventional *concept-formation* make to a large extent for inter-individual consistency of reaction in the normal population. Furthermore the normal subjects will comply in almost every instance with the explicit instructions to give one word and speedy responses. This tendency toward the "popular" was noted by Kent-Rosanoff, who even published frequency tables of responses given by 1000 normal subjects to their list of 100 stimulus words.[4] These investigators worked out a manner of computing a deviation-score, a score to designate the extent to which the reactions of any individual subject conform to the general trend of reactions given by the large "control" group. But this mechanical method of analysis misses essential aspects of deviant reactions: it does not take into account the qualitative differences of disturbance or deviation that occurred (and there are many such), it overlooks the fact that some deviations carry more pathological weight than others, and it neglects the fact that just a few outstandingly deviant reactions in an otherwise conventional set of reactions may be diagnostic even of schizophrenia.

For diagnostic purposes the reaction words are profitably looked upon in terms of their conceptual "closeness" or "distance" from the stimulus words. In terms of formal (not content) relationships these are the major directions in which deviations may occur. The yardstick for measuring these disturbances is the popular trend of responses given by the normal population as well as a scrutiny of the response itself. That is, there are reaction words which are infrequently given by the general normal population but which nevertheless do not appear either far-fetched or otherwise disturbed. Range of vocabulary plays an important part here. But the "popular" responses appear in general adequate for estimating the direction and degree of impairment of the formal relationship between stimulus and response.

* Anticipations toward "sensible" reactions as well as specific anticipations aroused by each stimulus idea and crucial in the final choice of reaction words are demonstrable. That the specific anticipation aroused by a single stimulus word is more general and less directed than those aroused by the 2 to 6 word stimuli used by Holzberg (see page 90, this issue) is apparent.

The "close" reactions: Types and Examples: (1) multiword abstract or functional definitions of the stimulus word, e.g., *beef*—"beef is meat from a cow" or "to eat"; (2) partial or complete repetition of the stimulus word, e.g., *doctor*—"doctor" or "doc"; (3) self-references, e.g., *mother*—"my mother" or "mine"; (4) images of things or persons denoted by the stimulus word, e.g., *house*—"I have a picture of my house"; (5) clang associations, e.g., *man*—"pan"; (6) no response at all; (7) affective expressions, e.g., *fire*—"phew." In none of these reactions can one detect any real conceptual departure from the original stimulus; none of these reactions can stand by themselves and all make explicit their dependence on the stimulus word for their pertinence. The implication of such "close" reactions is that either through extreme blocking or generalized retardation of the associative processes, the subject cannot think of new but related ideas and only by, in some way, concretizing the stimulus word, can he respond at all.

The "distant" reactions. Types and Examples: (1) mildly distant reactions where the relationship between the two words is comprehensible although slightly strained, e.g., *spring*—"woods" or *rug*—"dirt"; (2) distant reaction words where the subject's explanation of the connection is required before it can be confidently "understood", e.g., *world*—"man," *masturbate*—"Narcissus"; (3) extremely distant reaction words where even with explanation the relationship between the two words remains tenuous, e.g., *mountain*—"forever," *lamp*—"pencil"; (4) unrelated reaction words which even the subject cannot relate to the stimulus, e.g., *taxes*—"Swedish," *lamp*—"shuttle." These reactions represent a rough sequence of increasing distance between the stimulus and reaction words. The distance here refers to the fact that to render the reaction more understandable intermediate associative links must be assumed (or elicited from the subject by inquiry) which were passed beyond before a verbalized response was given. Although this process appears to hold even for conventional responses, in the distant reactions too many steps were taken before responding and the conceptual relationship between the two words grew weaker and weaker. The implication of these responses is that there is an unchecked speed, fluidity, luxuriousness of the associative processes which carries the subject beyond the conventional point of termination of the process.

If distant and/or close reactions occur in scattered instances throughout the 60 word list, and especially if they occur in connection with stimulus words likely to touch upon conflict-laden sets of ideas (love, intercourse, father, etc.) they may be considered symptomatic of the presence of such a set of ideas. Rarely, however, will the content of the reaction indicate directly the content of the conflict itself; rather, the disturbance in the formal relationship between the two words, in a setting in which nearly all of the responses are conventional, becomes symptomatic of the presence of affective disturbance. Here then an analysis of formal relationships bears its first fruit and dependence on the content of the reaction words (or their reaction time) is greatly reduced if not eliminated. In most normal

and neurotic subjects these scattered disturbances can only be noted and left for the psychiatrist to explore as to their significance and background. But sometimes there is a "diagnostic" pattern of such disturbances as, for example, that frequently found in the Association Tests of cases of addiction where the stimulus words with oral connotations (suck, breast, drink, party, bite, etc.) elicit the outstanding disturbances. Such patterns can also be established with respect to many personality characteristics by taking reference to the words with sexual, aggressive, familial, etc. connotations.

Among psychotics, however, it is frequent to find a massing of these deviations from the conventional. Depressive psychotics usually give many and extreme "close" reactions; their immobility of associative processes is indicated by these "close" reactions as well as by the presence of many long reaction times. Schizophrenics or borderline-schizophrenics usually give a good number of distant or more extreme reactions and indicate thereby their pathologically fluid and disorganized thought processes. But it must be remembered that just a few extreme instances of pathological increase of distance may be clearly diagnostic of schizophrenia. Therefore not only in terms of amount and kind of disturbances present should the test be evaluated but *degree* of departure from the conventional must be carefully assessed. The occurrence of a single clearly vulgar response in the association test record *of a woman* is frequently a crucial indication for the presence of schizophrenia.* Of course, some schizophrenic conditions characterized clinically by extreme blocking may show up on this test with many "close" reaction words also. Similarly *psychotic* depressions may give rise to some extremely distant reaction words although these will occur in a setting of generalized "closeness."

Reproduction of reaction words. Upon completion of the sequence of stimulus words we routinely re-read the list of stimulus words to the subject and ask him to repeat his previous reactions quickly. We find that almost all cases, even those showing psychotic disorganization, are able to reproduce the bulk if not almost all of their initial reactions. Subjects will state, "It isn't that I remembered; it was just what came to me and when it came to me I remembered that's what I said—except in some instances I immediately remembered what I said." In other words it is the usual case that subjects do not *recall* or clearly know what they said the first time; it is just that the same word comes to mind upon second hearing of the stimulus word. It appears, therefore, that the kind of organization of associative pathways is a relatively stable aspect of the

* This is not the case for male subjects, especially those with a working class or farming background.

subject's thought processes and can be counted on to allow for duplication of responses once conceived. This appears much less true, however, in connection with the "distant" reaction words. These in themselves imply some disorganization of the associative processes, or at least an extreme complexity and quantity of pre-response ideas; consequently they are in all groups—psychotic to normal—the most difficult to reproduce correctly when this is required. But the disturbances of reproduction have a more immediate diagnostic significance; just as the occurrence of scattered, close or distant reactions was considered to be symptomatic of the presence of emotion-laden, conflictive sets of ideas, so must be considered false reproductions or failure of reproduction. And, again, any massing of these disturbances points to a generalized disorganization of associative processes and is usually an indication of psychosis.

SUMMARY

Word association tests find their most fruitful clinical application when they are analyzed in terms of the relationship between stimulus and reaction words. Normal subjects and to a lesser extent neurotic subjects adhere to conventional conceptual relationships in their reactions; this concept-formation aspect of responses appears automatic. The disturbances in formal relationships take the form of sticking too close to the stimulus word or wandering too far away from it before a reaction is verbalized. A massing of either of these usually indicates a psychosis although even a few extremely distant reactions may be diagnostic of schizophrenia. A few scattered disturbances in either direction—but not too extreme—are usually symptomatic of the presence of conflict with respect to the ideas connoted by the stimulus words involved. Other symptoms of disturbance, specific or generalized, may be seen in long reaction times and false reproductions of the original reaction words. The hope that Association Tests can directly elicit content of the subject's conflicts which will be clear in his choice of reaction word should be abandoned and attention focussed on the thought processes of the subject as they find expression in the associative processes set off by the stimulus words under standard instructions.

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SOME USES OF PROJECTIVE TECHNIQUES IN MILITARY CLINICAL PSYCHOLOGY

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The role of the psychologist as an assistant to the psychiatrist has reached a well-defined level at Mason General Hospital, the Army's largest neuropsychiatric hospital. The psychiatrist is concerned with the total human being; he may turn to the psychologist as he turns to the neurologist, the laboratory technician, and the social worker to get the material to appraise the total personality. This paper confines itself to the uses of projective techniques in a specific military setting such as the neuropsychiatric service of this hospital.

The psychiatrist may and usually does ask specific questions about a patient of the psychologist. He may ask at what level of intellectual activity the patient is functioning, and what relation this level has to his level of previous functioning. He may ask what specific intellectual abilities and disabilities the patient has in memory, judgment, or visual-motor organization, or whether he is feeble-minded. The psychologist can give relatively valid responses by using standardized intensive intelligence tests such as the Wechsler Scale.

Frequently the psychiatrist asks for an appraisal of the patient's personality and for clues as to diagnosis. What are his traits and characteristics such as degree of submissiveness, aggressiveness, sociability? What are his areas of preoccupation—home, army, sex, etc.? What latent trends can be discovered? What light can be thrown on the psychiatric classification to which he belongs? Is there evidence of psychosis? Is there any change in his condition as a result of treatment or hospitalization? Are there psychological signs of organic deterioration? Here more subtle distinctions are involved and this may make it necessary to utilize more subtle and sensitive techniques. Some of the answers to these questions may be indicated by a careful analysis of standard measuring instruments of intelligence such as the Wechsler-Bellevue Scale or the Wechsler Army Mental Ability Scale. However, when these clues are bolstered by data procured through the use of projective techniques, the probability of the accuracy of the answers is increased.

Thus, at Mason General Hospital, in our work-up of patients, we make use of a combination of direct and projective techniques. By a projective technique we are referring to an ambiguous test situation about which the patient is asked to do something. He is given latitude to organize it in

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his own way and it is almost impossible for him to guess at the significance the psychologist will attach to his responses. Our testing battery consists of the Wechsler, Bender Visual Motor Test, drawings of a man and a woman and simple projection sheets of the sentence-completion type, the latter two being given to practically all patients. Where further personality exploration is needed, the Rorschach test is administered by trained Rorschach workers.

For many of the patients referred to us and for many of the questions put to us by the psychiatrists, the use of the standardized Wechsler Scale proves sufficient since it is used not merely to measure I.Q., but is interpreted dynamically in terms of scatter, test behavior, and quality of response. Frequently, however, the Wechsler Scale is not sufficiently sensitive. For example, we recently tested a psychotic who maintained sufficient superficial contact with reality that no obvious psychotic signs or deterioration were revealed in the Wechsler Scale. The free atmosphere and greater latitude of the projective techniques permitted the patient's disassociated and sick attitude to life to come to the surface and express itself.

We utilize two kinds of "sentence-completion" projection sheets: one, the Tendler Emotional Inquiry,[1] consists of a series of twenty beginnings of sentences prone to elicit emotional reactions:

TENDLER E.I. TEST

Sample: I eat when ——; I sleep when ——; I read ——.

Test: My hero is ——; I get angry when ——; I feel happy when ——; I love ——; I hate ——; I feel hurt when ——; I worry over ——; I feel sorry when ——; I make believe ——; I brag about ——; I feel proud when ——; I have a grudge against ——; I become stubborn when ——; I pity ——; I feel ashamed when ——; I am afraid when ——; I like to ——; I become disgusted with ——; I tell lies when ——; I wish for ——.

The patient is asked to complete each of these sentence beginnings with the first thought that comes into his mind. Ample space is provided on the test form for his answers.

Another type of sentence-completion sheet was devised by one of the enlisted psychologists[2] now at Mason General Hospital, the content of which is taken from common experiences of the soldier:

SELF-IDEA COMPLETION TEST (FINISH THESE SENTENCES AS RAPIDLY AS YOU CAN. WRITE DOWN THE FIRST IDEA THAT COMES TO YOUR MIND. LET THIS BE AN EXPRESSION OF YOUR REAL FEELINGS)

I want to know.....; I feel.....; At bedtime.....; Army food.....; My worst .....; Back home.....; I regret.....; The best.....; Other people usually.....; If my mother.....; What puzzles me.....; If I had my way.....; Most sergeants .....; Other men.....; My nerves.....; My childhood.....; My greatest fear .....; My best friends.....; The most dangerous.....; I suffer.....; My father used to.....; My hardest job.....; The men in my company.....; My strongest

.....; A wife.....; The happiest time.....; My great hope.....; The only trouble.....; If only the Army.....; The sharpest pain.....; I hate.....; I am very.....; Most officers.....; My job here.....; The future.....; In the barracks.....; My mind.....; I failed.....; My education.....; This war.....; I secretly.....; I cannot understand what makes me.....; My old job.....; Most girls.....; My family never.....; My most important decision was.....; My greatest worry is.....; I envy.....; If only.....; Today, I.....: ABBREVIATED FORM: I feel.....; The Army is.....; My father used to.....; I want to know.....; My worst.....; A woman.....; My greatest hope.....; If only.....; I don't like.....; This war.....; I secretly.....; Most girls.....; If my mother.....; Other soldiers.....; Before I was in the Army.....; I am best when.....; My most dangerous.....; I suffer.....; My nerves.....; My greatest fear.....; What puzzles me.....; Right now.....; Most officers.....; I failed .....; My education.....; I envy.....; What annoys me.....; My greatest worry is.....; The happiest time.....; When I was a little boy.....;

These techniques may be applied either as a pencil and paper test or as a test involving person-to-person relationships. We prefer to utilize them as person-to-person tests since that permits observation of blocking and changes in the content of thought.

These techniques have helped to answer many questions of the psychiatrists where more direct techniques have failed. They have reflected the presence of anxiety, guilt feelings, degree of insight, and vague as well as specific complaints. Frequently, they have shown the relatively good mental control and coherence of the psychoneurotic as opposed to the remoteness and unrelatedness of a psychotic. Areas of preoccupation and concern appear; the direct, primitive, impulsive approach of the psychopath frequently reflects itself; attitudes toward the army, other soldiers, home, family, hospital, also are often brought to focus.

Some examples of the utilization of these techniques follow. One patient eventually diagnosed as a schizophrenic, gave these among his responses: *My greatest hope*..."is to advance continually in the scale of civilization"; *I hate*..."nothing, for it violates that law of advancing civilization"; *If my mother*..."answered all my youthful questions—I would be higher in the scale of civilization today"; *The most dangerous*... "thing to civilization is that which kills the soul of progress." These demonstrate the perseveration, the unrelatedness, the preoccupation and abstract language that frequently characterize the schizophrenic.

Another case, eventually diagnosed as a sexual psychopath, gave these among his responses: *I feel*..."lousy"; *In bed*..."a young man's fancy" —; *A woman*..."is good for only one thing"; *If only*..."I were out of the Army"; *This war*..."is pointless." These responses show impulsivity, an anti-social attitude, indifference to social values, and abnormality in respect to sex concepts.

In contrast to the use of drawing in the Goodenough Test of intelligence, we have utilized drawings of a man and a woman to investigate personality

makeup and the fantasies and preoccupations of the patient. Although there has been little attempt to standardize interpretations of drawings in the psychological literature, we have often found certain diagnostically significant characteristics. In schizophrenic drawings we often find evidence of bizarreness, the alternation of good and bad detail, and preoccupation with insignificant body parts such as the navel. Among certain kinds of schizophrenics we find almost uniformly a type of drawing which we call an "empty shell." Only the outline is produced, the normal details of body structure being completely ignored. In many depressed patients, because of an inability to expend energy, the size of the drawings is affected, only a small section of the sheet of paper is used, and the lines are unusually light. In patients who are withdrawn, we frequently observe an inadequate handling or omission of such details of social value as clothing. On the other hand, meticulous, detailed drawings are often produced by obsessive neurotics. This tendency is also present in psychotic patients who have obsessive inclinations, but here form and content are poor. Sexual preoccupation and disturbance in sexual functioning is sometimes reflected by a discrepancy in the handling of male and female figures and in the treatment of the genital areas. The drawings may give clues which help to differentiate mental deficiency from the functioning ability of a person of otherwise higher intellectual ability who is showing regression or deterioration.

Although our experience with drawings is not sufficient for standardizing this procedure, the considerable degree of uniformity of findings among all of our clinical psychologists at the hospital indicate the value of this projective technique as another tool in picking up clues or in verifying findings of other tests.

Where the need is indicated for more subtle analysis of personality, we have utilized the Rorschach Test. The use of this technique has been limited because of the fact that only one-half of our psychological staff is sufficiently trained to utilize it. Our experience shows that it is probably the most valuable projective personality test, but the time and skill required in its interpretations make its use on a wholesale scale inadvisable in a military setting where the emphasis is not on the intensive study of psychodynamics, but on the best possible treatment and disposition in a relatively short period of time.

The use at this hospital of the Thematic Apperception Test has been limited because of the fact that the problems of scoring and interpretation of the test have not been satisfactorily solved.

In all of our work with the use of direct or projective techniques, the psychologist does not offer a definite diagnosis. He gives to the psychiatrist only a working hypothesis which derives from the test findings.

Not once in our experience here have we found that a psychiatrist considers this competition in diagnosis.

Our experience with projective techniques shows that they are more than a valuable adjunct of other psychological tools—they are essential if we are to answer competently many of the questions put to us by psychiatrists. One point which must be stressed is that they can be dangerous in the hand of untrained persons. Observations of the psychologists at Mason General Hospital show that the greatest usefulness of projective techniques is in the hands of those workers who have a good clinical sense of the dynamics of human personality.

Another danger that should be emphasized, we feel, stems from the very nature of projective techniques. By definition, they attempt to reveal the hidden regions of personality. As such, they are capable of bringing unconscious forces into play to the discomfort of the patient. Recently, a patient at our hospital was given a psychological examination including a Rorschach Test which showed considerable sexual preoccupation that had not been observed during the psychiatric examination. On a retest the Rorschach was given again to the patient. When presented with the first card, he broke down, wept and asked that the test not be given to him. The emotions that are stimulated by projective techniques must be carefully handled in terms of sufficient initial orientation to the test, care in the methods employed in urging the patient to respond against his will, and carefully gauging and integrating the patient's feelings after the examination is completed.

In spite of these limitations, however, projective techniques do play and must continue to play a vital role in military clinical psychology. They are capable of exploring areas which more direct psychological tests cannot probe and they have been accepted as valid tools for psychological study of patients, by the psychiatrists with whom we work.

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THE SCOPE OF CLINICAL PSYCHOLOGICAL SERVICE IN THE ARMY

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Since early in July of 1944 the Army's program of clinical psychological services in medical installations has made great strides. The initial phases of the program have been described adequately in earlier articles.[1, 2] In the present summary an effort is made to stress the breadth of the service which the psychologist has been able to render in the various types of medical installations to which he is now assigned. This information may serve as a guide post for those who desire to make use of psychological collaboration in civilian hospitals, clinics, or in private non-institutional practice.

One should bear in mind that the effective aid which the psychologist can render in civilian endeavor, as well as military, is premised upon the whole-hearted cooperation of both the psychiatrist and psychologist. The team work relationship has been conclusively demonstrated as an effective and practical factual event in the Army. It surely should be equally possible and desirable in civil practice.

SERVICES IN MILITARY HOSPITALS

Psychologists are now assigned to a majority of named and numbered general hospitals of the Army. In addition some of the larger regional hospitals and station hospitals likewise have received a proportionate share of trained clinical psychologists. In general the policy has been to assign clinical psychologists on the basis of one per 1,000 beds, except to psychiatric hospitals where the assignment policy is one per 200 beds.

Approximately 50% of the psychologist's time is devoted to the mental examination of the patient. This includes redetermination of intellectual level as revealed by the Army General Classification Test, the Bellevue-Wechsler or other tests, with the primary purpose of yielding a clue to present mental status and affording a basis of comparison with earlier tests of a similar nature. The need for this type of comparison is clear when one considers that a large proportion of the soldiers in hospitals have been subjected to acute mental traumatization and it is important to determine just what this has done to the basic mental processes.

In addition, many of the hospital psychiatrists have called upon the psychologists who are competent to do so to administer a number of the projective tests such as the Rorschach and the Murray Thematic Apperception Test. Such tests supply supporting data that assist in the

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interpretation of material gained from the direct interview of hospitalized personnel. This is especially true in the examination of the psychoneurotic and psychotic patients as well as those suffering from organic brain damage resulting in convulsive seizures and the like. Parts of the case history taken from the psychological point of view are often delegated to the psychologist. All pertinent data are discussed in conference with the psychiatrist and a decision is reached as to the nature of the vocational assignment within or without the military environment which it is anticipated the patient will ultimately be capable of assuming.

Besides their primary duties, many clinical psychologists in the general hospitals of the Army engage in a number of related activities such as leadership in group psychotherapy sessions. This is done under close scrutiny of the psychiatrist and many times in collaboration with the psychiatric social workers of the hospital. Some general hospitals are fortunate in having psychologists with extensive experience in electrophysiology to whom the duties connected with electro-encephalography are delegated.

Close coordination exists between the psychologist, the occupational therapist, and the Information and Education Officer whose services in the hospital are concerned with stimulating the patient to return to normal function through mental and physical activity. The information which the psychologist procures from the patient and his doctor enables him to be of great service in assisting the O. T. specialist and the I and E Officer.

In the general hospital the well trained psychologist working as a collaborator and professional associate of the psychiatrist, the social worker, the occupational therapist, the Information and Education Officer and the Classification Officer, has the opportunity to see the results of his psychological efforts as applied to the patient.

WORK IN THE CONSULTATION SERVICE (MENTAL HYGIENE UNITS) OF ARMY SERVICE FORCES AND ARMY GROUND FORCES TRAINING CENTERS

For several years now the training centers of the Ground and Service Forces have offered a Consultation Service to personnel suffering from minor maladjustments. These have been discussed at length by Freedman.[3] The mission of the psychologist in these organizations, like that of the psychiatrist and the social worker, is concerned primarily with mental hygiene.

The individual is referred to the Consultation Service by line officers, by medical personnel, chaplains, and many others, the referral being made in an attempt to prevent the soldier from succumbing to the pressure of social, economic or other psychological stress. It is apparent that insofar as such aid is effective it is a useful device for conserving manpower within the Army.

The psychologist is responsible for working up an effective history augmented by such psychometric procedures as are necessary to fill in the gaps in the appraisal of the competency and efficiency of the soldier. Here the psychologist serves more in the role of a screening examiner who determines whether or not the examinee needs psychiatric examination and care. The number of men referred to these "clinics" is so large that there would not be enough psychiatrists to meet the demands if some preliminary sorting was not done for them. The psychologist trained in the views of the psychiatrist with whom he is serving is well qualified to do this. He is called upon to administer and interpret such tests as the A.G.C.T., the Army Individual Test and numerous tests designed to measure aptitude for various categories of military specialties such as the mechanical, clerical and radio fields. Occasionally study of personality problems may call for the use of the Rorschach and T.A.T. or similar projective device.

In the Consultation Service more emphasis is placed upon psychometrics in contrast to the broader clinical activities in the hospital. However, the skilled psychologists are beginning to enlarge their activities in the mental hygiene unit by relating them to the program of the Training Center. Many of the problems in Training Centers are focussed around difficulties occuring during the training cycle. Slow learning, dissatisfaction with assignment to a particular kind of training, internal strife occurring as a result of repetition of previous training or practical experience are but a few of the causes of maladjustment. Detection of these factors and their basis can do much to make training more pleasant and less mentally disturbing, provided that the cooperation of the trainers can be secured. This is possible only when the relationship between the psychologist and the training personnel is most effective. Since readjustment of assignment is frequently desirable, cooperation with the Classification and Assignment personnel of the Training Center is important.

The psychologist in the Training Center, as in the hospitals, has an assignment that is stimulating and challenging. The initiative, ingenuity and professional competency of the psychologist determine to a large extent his success.

PSYCHOLOGICAL ACTIVITIES IN REHABILITATION CENTERS AND DISCIPLINARY BARRACKS OF THE ARMY

A third type of military installation in which the clinical psychologist has found great opportunities is the military penal institutions which are the Disciplinary Barracks and the Rehabilitation Centers. Here also the psychologist is a member in the psychiatrist-psychologist-social worker team.

The aim in military penology is to return as many prisoners to effective service in their units as possible, promptly and with the assurance that the

likelihood of a recurrence of a breach of military conduct will be diminished. The psychologist is responsible for providing the psychiatrist, the Classification Officer and other interested members of the Staff with data relative to the mental status, personality, and special aptitudes of the prisoners. Many of the men in these institutions have limited educational backgrounds and require as part of their rehabilitation some educational treatment. The psychologist is responsible for determining their needs and making the appropriate recommendations.

Psychotherapeutic procedures are essential for many prisoners. Group psychotherapy in particular is a valuable part of the treatment. Many of the rehabilitation centers and disciplinary barracks use the psychologist to assist the psychiatrist to carry on these activities. Mental hygiene procedures as a prophylaxis against recurrent criminality can be used with all except the case-hardened criminal and the psychopath. Careful historical review of the prisoner's background to ascertain the basis for deviation from acceptable behavior is made by the psychologist, social worker, psychiatrist and Classification Officer. An effort is made to correct such factors as misassignment of skills, deficiencies in education, socio-economic maladjustments in the family, lack of proper military knowledge and deficiencies in discipline. The psychologist assists in sorting those who give promise of becoming "good risks" for return to duty from those who are unlikely to be made into soldier material and who need to be dismissed from military service or incarcerated in appropriate long term penal institutions.

The psychological responsibilities in this assignment, as in those which have been discussed, are great. Those who are engaged in military penology agree that the psychologist's contribution is highly valuable.

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VOCATIONAL COUNSELING IN REHABILITATION

By BENJAMIN BALINSKY, Ph.D.

This paper is designed to give a picture of a vocational counseling project in a public employment service, and to present certain principles which have developed in the course of the project.

The project was set up through the Vocational Advisory Service of New York, formerly the Vocational Service for Juniors, which for ten years has conducted a consultation service[1] offering vocational and educational guidance to young people referred to it. The staff in a branch office of the United States Employment Service felt the need for help with a large number of applicants who would not or could not get or hold jobs and who were not willing to go to the Consultation Service for guidance. To fill this need the Vocational Advisory Service in June, 1943, assigned a counselor with clinical psychological background to spend three half-days per week, about ten hours, directly in the employment office, to act as special consultant to the interviewers. Those applicants designated for record purposes as "difficult-to-place" were referred to him.

By December 15, 1944, 386 of these difficult-to-place applicants had been interviewed, 347 male and 39 female. Of the males, 145 had neuropsychiatric 4F draft classifications and 103 had neuropsychiatric discharges from the armed forces. The remaining males were mental defectives, and were over or below draft age. The problem of the "difficult-to-place" thus defined itself as concerning mainly the difficulties of draft age neuropsychiatric cases, in making adjustment to jobs.

While carrying on this project, the writer acted in a dual capacity: as a counselor in the Consultation Service, and directly, as consultant in the employment service. The topics to be discussed in this paper are:

1. The interview
2. The use of psychological tests
3. Cooperation between vocational counselors and the employment office
4. The use of outside facilities
5. The need for research

THE INTERVIEW

Both in the work in the Consultation Service and in the employment office, the writer has found that the interview is the most significant part of the counseling process. It is in the interview that the individual has an opportunity to see himself as he is adjusting to work and what that may imply. He begins to understand what he wants, what is possible for him, and how he may go about getting it. He may ask questions about job

requirements, opportunities for advancement, the conditions of work, the pay. If he intends to go to school he will want to know what courses are best, whether he should go out of town or not, the matter of finances, his family's wishes, whether it would be best to attend day or evening school, etc. All information is utilized while the individual works out his plans under the guidance of the counselor.

Obviously any counselor must have available a good deal of up to date information about jobs and schools.[2] Much of the job information can be obtained through the United States Employment Service.

In the writer's work with difficult-to-place applicants in the employment office, without the aid of the full Consultation Service procedure, the interview was of major importance. Psychological tests were not used for several reasons: (1) The people referred came to be sent on a job, not for counseling. (2) Their problems were emotional, not simply vocational. (3) In general, they were avoiding the emotional problem. In this connection, the preliminary report of the Committee on Psychiatric Needs in Rehabilitation[3] is revealing. Only 26% of the neuropsychiatric draft rejectees want psychiatric help, and 29% want vocational help; only 25% of those servicemen discharged on neuropsychiatric grounds want psychiatric help, and 49% want vocational help. Of the 29% of the rejectees who want vocational help, only 24% are receiving it; of the 49% of discharged men who want vocational help, only 14% are receiving it.

The United States Employment Service is a public agency and any person can come to it for a job. Thus neuropsychiatric applicants who otherwise would not receive vocational counseling find themselves in a position where it is made available to them. The neuropsychiatric applicant may be recognized in the employment office by his draft status, the nature of his discharge from the service, the peculiarity of his behavior where this is obvious, the difficulty in interviewing him, and perhaps most often, by his poor work history.

Certain principles associated with the interview which have been learned from dealing with these neuropsychiatric cases are also applicable in the usual vocational situation. These are:

(1) The purpose of the interview should be established immediately: The individual wants a job, but has found difficulty in getting and keeping one. He will react favorably if he understands the counseling interview as a way of helping him get established in work.

(2) The interview should be kept on the level of job adjustment. This involves trying to understand the personality of the individual as it is manifest at work, and, more important, bringing the individual to understand himself in the work situation.

(3) During the interview the counselor needs to arrive at some estimate of the individual's work habits and attitudes, in order to recommend proper placement. To enable him to talk in practical terms to the employ-

ment people, the writer kept in mind the following eight points, while interviewing: (a) the attitude of the applicant regarding his own status in relation to others in society; (b) drive or ambition; (c) relation to authority or superiors; (d) relation to peers; (e) quality of performance; (f) sense of responsibility; (g) persistence; (h) initiative. Dynamic descriptions of these eight characterisics under various circumstances are possible by means of the Rorschach Test,[4, 5] but can also be gathered through the interview.

(4) Decision as to the kinds of work and work environment that would most favor the individual's adjustment to a job should be the end result of the interview. The final decision also entails the individual's accepting the realistic conditions of work and meeting them. Often preliminary steps have to be taken, and the individual should be led to understand the reason for these steps, and be helped to decide to take them.

(5) During the interviews these neuropsychiatric cases were led to discuss their previous jobs, their success in mastering the specific skills required, their reasons for leaving, etc. During this discussion a record was made of the specific job conditions that were disrupting.

It was learned that the factor of traveling to a job was very important to some of the people. Subway riding was particularly upsetting to many and the matter of being with crowds and possibly being pressed against was by no means a small factor in their aversion to traveling a long distance to work.

There were some individuals who wished to have responsibility in a job; they had never had any, but had always felt deprived of opportunity. Others, anxious ones, would not accept responsibility and a few were fearful to take a salary commensurate with their experience and training because they felt they could not measure up to the demands it meant to them. Some could not stand close supervision on a job, especially if they felt it was "prying." Still others objected to working in a noisy place, or where there was too much dirt, grease or strong odors. Some could not work with "crude" people; some preferred to be in a small place where they would not be conspicuous; some preferred to work with people their own age, others with older people.

In each instance, it was accepted that these people could not work under certain specific conditions. It was important for the counselor to know these specific conditions, as well as the interests and aptitudes, so that he could pass them on to the employment person who would utilize the knowledge to avoid as many of the trying conditions as possible and still place the individual in the proper field of work. Of course, these difficulties are symptomatic of deeper maladjustments. Whenever possible, they were used as a lever to suggest psychiatric treatment.

(6) If subsequent interviews are needed, they should be on the basis of actual work experience or attempts to find employment. The realities of the situation should be kept in focus, to provide an understanding of all that a job adjustment involves.

PSYCHOLOGICAL TESTS

In the Consultation Service, tests are arranged for the applicant for vocational guidance after an interview with his counselor in which the

individual's interests, schooling, personality needs, the job requirements and possibilities, finances, and other relevant matters are explored. Findings are supplemented later by school records and sometimes by information from agencies knowing the client. In the interview, tests are explained as objective aids giving clues to potential abilities. Tests employed by the psychological department are used not to measure success in any specific job, but rather to define the areas of potential ability and the levels within each area. They are classified into four general categories: academic, clerical, manual and spatial. The tests* include:

A. Academic Tests

1. The O'Rourke vocabulary tests—without a time limit, therefore a measure of "power" or level of learning ability.
2. Otis, Higher Examination; or, more recently, the Personnel Test by Wonderlic and Hovland—speed of learning is a factor here.
3. An Abstract Verbal Reasoning Test—devised in the Vocational Advisory Service and individually given to ascertain independent judgment and expression.

B. Clerical Tests

1. The Minnesota Vocational Test for Clerical Workers—a simple routine checking test, originally designed to measure only speed of perception. We have devised a method for checking accuracy as well.
2. The Simple Posting Test—a short test devised in the Vocational Advisory Service and patterned after an actual clerical task. This involves understanding directions and executing them. Scores are for speed as well as extremes of accuracy.
3. The Complex Classification Test—a complex practical business problem involving selection among choices, judgment and expression. No time limit. Devised in the Vocational Advisory Service.
4. More specific clerical tests like filing, spelling and arithmetic.

C. Manual Tests

1. O'Connor's Finger Dexterity Test—a simple, specific test of finger dexterity scored for quality as well as speed.
2. O'Connor's Tweezer Dexterity Test—a simple, specific test for the use of a small instrument. Speed is scored. Quality of work is described.
3. Ziegler's Rate of Manipulation Test—placing and turning. Simple and specific test of coordination of the larger muscles of hand and arm. Scored for speed. Quality described.

* A-1, B-1, C-3 can be obtained from the Psychological Corporation, 522 Fifth Ave., New York. A-2 can be purchased from E. F. Wonderlic, 919 N. Michigan Ave., Chicago; D-1 from the Marietta Apparatus Co., Marietta, O.; C-1, C-2 and D-2 from the Human Engineering Laboratory, Stevens Institute of Technology, Hoboken, N. J. Information about the rest can be obtained from the Vocational Advisory Service, 95 Madison Ave., New York.

D. Spatial Tests

1. The Minnesota Formboards, A and B—simple tests of spatial ability. Scored for speed and quality.
2. O'Connor's Wiggly Block—a three-dimensional, rather complex spatial problem. Scored for speed as well as quality.
3. Kohs Test—a complex spatial test, involving analysis and synthesis, which is individually administered to allow for qualitative description of the individual's performance. Score is time on design # 15. Separate report on performance.

Aptitude tests, in general, give leads as to potential ability, and the scores made on them cannot yet be accepted as absolute indicators. There have been many studies on what they indicate in relation to kinds of jobs. Except for the Wiggly Block, we have found that the norms for the various tests were not too adequate and therefore have established our own norms on a group representative of the population we have been counseling. The test results should always be examined in the context of school grades, work experiences and hobbies, as well as likes and dislikes. They should also be studied intrapersonally to note how any individual's test results group. It is often found that an individual shows an area of specialization in the manual and spatial tests, or the clerical tests, or the easier tests or the speed tests, etc. These constellations of specialization are usually reliable in terms of their fitting into the individual's background of training and experience.

These tests do not have to be administered in a given order. It has been the custom of the Consultation Service to give the Vocabulary Test first. Manual tests may precede the other kinds of tests or follow them. The arrangement in testing should be adapted to the most efficient flow so that no person is ever idle except during the general rest period.

Individually administered tests may be called for if the person is interested in going on to college, or if there is a question of mental level or instability and a more analytic description is required. We have used the Abstract Verbal Reasoning Test, the Kohs Block Design Test (in modified form) and the Wechsler-Bellevue Intelligence Scale, as individually administered tests.

The Abstract Verbal Reasoning Test may be given to those individuals near high school graduation, or who intend to go on to college and whose interests or successful experiences are verbal. The Vocabulary and Personnel tests may be substituted for this test as a measure of school success. The main value of the Abstract Verbal Reasoning Test comes from the individual administration and the qualitative descriptions obtained.

The Kohs Test (modified) is an excellent measure of technical ability on the college and engineering level where planning and reasoning are required. It is undoubtedly more reliable than the Wiggly Block because of its greater length and ascending levels of difficulty. The Consultation Service has worked out an analysis of the approach to the test in terms of focus and field. The more technical people build the designs by focussing on each block separately without regard to the smaller design patterns or the total design. Other individuals, perhaps more suited to aesthetic designing, build the designs by focussing on the design parts. Persons who

are both artistic and technical use a flexible combination of both techniques, shifting their focusses without difficulty. Such data as well as the descriptive data about persistence against failure, recoverability, gains in achievement, etc., have been found useful in evaluating the subject's performance.

The Wechsler-Bellevue Intelligence Scale may be given when there is a discrepancy between years of schooling and the counselor's judgment of the individual's intellectual ability; when the individual seems to be mentally defective; when he has a history of mental illness or seems to be emotionally disturbed.

A questionnaire allowing for spontaneous expression of the attitudes and emotional development of the individual should be included in every test battery.

The psychological test report provides not only an array of scores, but also qualitative descriptions on such matters as speed of adjustment to the test, rate of progress, effort, rhythm of work, and reaction to difficulty. In the consultant work with the employment office, this kind of qualitative description proved to be especially fruitful.

Work samples as devised by O'Rourke[6] to arouse and develop interests in the individual seemed likely to reveal much about the individual's work habits, attitudes, and adaptability to the work, so they were tried out for a time in the Consultation Service as a test device.[7] While they were difficult to use as aptitude tests because of the complexity of factors involved, they provided an opportunity for qualitative, descriptive material about the individual at work which may prove to have high individual prognostic significance.

COOPERATION BETWEEN VOCATIONAL COUNSELORS AND THE EMPLOYMENT OFFICE

In vocational counseling, cooperation with an employment office is extremely helpful. The employment office has the task of finding the actual job, and therefore must know enough about the individual to interpret the vocational counselor's recommendations. The Consultation Service has established the procedure of a conference of the counselor, a consultant, and the referring person, on each applicant. Where the applicant was referred by the employment office, this means that a member of the employment office staff attends the conference. All information relevant to the individual is discussed, and a tentative plan is made. After the individual is seen again by his counselor, and the work plan is decided upon, he is directed back to the employment interviewer who was present at the conference. This interviewer utilizes the information and point of view developed at the conference in discussing specific jobs with the applicant. Where necessary, the interviewer will solicit employers in the interest of a successful placement. In most cases he is willing to try many times to place the applicant and all concerned learn from each placement. Very rarely does an employment service worker urge that the

applicant take any job that is available, rather than make an effort to find employment more satisfactory and lasting in terms of personality needs and aptitudes.

THE USE OF OUTSIDE FACILITIES

It is well known and generally accepted not only that work is therapeutic but that individuals with well-defined neurotic patterns can do very effective work under the proper conditions. Through vocational counseling the neuropsychiatric patient may become more aware of his emotional difficulties, and be helped to achieve his best work adjustment. At the same time, vocational counseling of the neuropsychiatric case necessarily involves the cooperation of psychiatric and social work facilities.

Applicants were often found to be resistant to and unprepared for psychiatric help or referral to a social work agency. However, through the interview it is sometimes possible to help the individual see the need for other than vocational help, and to accept it. Where such help is not accepted, a work adjustment can sometimes be effected, nevertheless.

Of the 248 neuropsychiatric males of draft age seen by the writer in the employment office, 17 of the rejectees and 12 of the discharged veterans accepted psychiatric referrals. Thirteen of the rejectees and 9 discharged veterans accepted social agency referrals. All those who accepted social agency referrals were faced with a bad home situation from which they wanted help to extricate themselves, or were living alone and managing poorly. These small numbers indicate that much work will have to be done with these applicants, without the aid of psychiatry or the social work agency.

Where referral is made to a psychiatrist or a social work agency, the vocational counselor must be prepared to see the individual as often as needed to get him adjusted to a work situation, if he is considered able to undertake employment, and to help him plan his work in accordance with changes in his attitudes and general adjustment.

THE NEED FOR RESEARCH

Vocational guidance is expanding and everyone is aware that greater expansion is in prospect, especially for the returning veteran. A large proportion, possibly as high as 40 or 45 per cent of the returning veterans will be neuropsychiatric cases, according to the preliminary report of the Committee on Psychiatric Needs in Rehabilitation cited previously. The United States Employment Service has, of course, been designated by law as the agency to find employment for these veterans. It will thus be a large referral agency for vocational guidance. How can employment interviewers best recognize the need for referral of applicants to vocational

counselors? Should a vocational counselor serve directly on the staff as an in-between? What about interpreting the needs of the individual in terms of the specific job?

There is need for data on how individuals with various kinds of behavior, interest and aptitude patterns adjust themselves to different jobs. It is necessary to know the psychiatric diagnosis of the individual, but for vocational guidance it is more important to know the dynamics of the mental condition as it points to the most suitable kind of work. The vocational counselor must be able to serve as an interpreter of the mental condition into practical work-a-day terms. This necessarily requires coordination among all those professions which deal with the individual, including psychiatry, social work, and the employment offices. Research is most vital in working out this complex relationship. The vocational counselor, in the writer's conception, stands in the middle ground between the psychiatric services and the employment office. He can contribute much by acquiring through tested research the understanding of how and where to vocationally direct men with various constellations of personality, interests, work experience and aptitudes.

Research on certain aspects of the interview might also be done. For example, could the eight points mentioned under the interview be experimented with to determine the validity of the judgments against what actually happens on the job? If we can judge the work habits of the individual with high reliability and validity we will have made a great step forward in making more realistic job recommendations to the employment office.

Psychological tests must also be made more effective aids through research. Clinical instruments like the Rorschach can be adapted to give information about work habits and attitude toward work. At present the language of interpretation is too abstruse for vocational purposes. The clinically trained vocational counselor can contribute by re-interpreting the Rorschach into predictions about adjustment to work and work conditions. Questionnaires might also be constructed to furnish leads to vocational adjustment.

The idea of the work sample merits experiment. How can it be used for predicting aptitudes and how valid are the descriptions about work habits? Also, the scores on many of the aptitude tests could be made to have more precise meaning. In vocational guidance the individual is tested for aptitudes in general areas of work, such as clerical, manual, spatial or technical, not for skill or potential skill on a specific job. A study of the standardization data will reveal relatively low individual prognostic value. Perhaps research should strive toward fewer aptitude tests, and concentrate on defining what we are testing for, in order to make tests that are more accurate in individual prediction.

Such findings would be useful in vocational guidance of well-adjusted applicants, as well as of neuropsychiatric cases. Since the field of voca-

tional guidance is becoming increasingly important, its techniques must be put to the test of research with the aim of developing new and better techniques.

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THE NEW ARMY INDIVIDUAL TEST OF GENERAL MENTAL ABILITY*

By DAVID RAPAPORT, PH.D.

The description of the history of the "New Army Individual Test of General Mental Ability" presented in the October, 1944, issue of the *Psychological Bulletin* states that the aim in designing this test was to obtain an individual test adapted to army conditions, to yield a more valid measure of abilities than group tests do, and to cope with the needs of army hospitals, convalescent centers and the like, which had requested an individual test for use in conjunction with other clinical techniques in psychiatric diagnosis. As a gauge of general mental ability the test is admirably well-constructed. With regard to clinical diagnostic usefulness it has valuable features but also serious limitations. It appears, however, that the latter can be easily remedied. We shall discuss this test only from the clinical-diagnostic point of view, endeavoring to (a) enumerate its advantages, (b) enumerate the points wherein its clinical limitations could be remedied, (c) advance some minor suggestions concerning the administration of the test, and (d) offer some general suggestions for increasing its clinical usefulness.

(a) THE CLINICALLY ADVANTAGEOUS FEATURES OF THE TEST

1. The fact that the test consists of well-balanced verbal and performance parts is a major advantage for the diagnosis of any depressive conditions and for the differential diagnosis of neurotic from psychotic conditions.

2. The inclusion of a memory test gives this test a major advantage over the Bellevue Scale, which lacks one; the presence or absence of, and the kinds of, impairments of memory functioning are important diagnostic indicators, especially in diagnosing schizophrenias.

3. The Similarities-Differences and the Shoulder Patches Tests are, as we see it, tests of concept-formation and it is a major diagnostic advantage to have concept-formation tested both on the verbal and non-verbal levels because the impairment of *verbal* concept-formation usually is referable to profound maladjustment, whereas impairment of only *non-verbal* concept-formation is more likely referable to acute, anxiety-ridden and transitory conditions.

4. According to our clinical understanding—and we have some statistical substantiation for this—Digit Span is a test of *auditory* attention while

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Trail Making is one of *visual* attention. The inclusion of such tests of attention is a diagnostic advantage because their impairment indicates the degree of anxiety present while their exaggerated superiority refers to the presence of schizoid processes, or in rare cases of an obsessive condition.

(b) WAYS OF INCREASING THE DIAGNOSTIC USEFULNESS OF THE TEST

1. The test at present appears to aim solely at obtaining a rating of total intelligence and does not have any equated subtest scores. Equated subtest scores allow for *scatter analysis* which is indispensable in diagnostic work with an intelligence test. Scatter analysis takes diagnostic work with intelligence tests out of the realm of subjective observations and judgments, and into that of objective and statistically verifiable diagnostic data. With the standardization data extant it should be very easy to develop an equated score-scale.

2. The test at present includes no Vocabulary Test. We have found that vocabulary resists impairment by maladjustment to a great extent and thus may be taken as a rough index of the pre-maladjustment level of intelligence. For this reason vocabulary may serve (if the subtest scores are equated scores) as a basis for estimating the impairments of the other subtest scores. Our data also show that of the subtests used in the present test, the Similarities-Differences is the most resistant to impairment by maladjustment; however, it is still a much more vulnerable test than vocabulary. Since in the course of the standardization of the test, those tests from among which the present six subtests have been selected, included a Vocabulary Test, it should be easy to amend the Test with the already standardized vocabulary. The administration of the latter may be omitted when the test is given for purposes other than diagnostic. The vocabulary score would not contribute to the intelligence rating and would leave the present mode of calculation of this rating untouched.

3. The very useful Story Recall Test includes a supplementary set of questions rather than a Delayed Recall Test. Inasmuch as improvement or impairment in Delayed Recall helps to differentiate benign from malignant maladjustments, replacing the "questioning" with a Delayed Recall Test would increase the diagnostic potency of the test without lengthening it. The story itself has, in comparison to other stories used in tests and examinations, few aggressive implications; since the subject's handling of these aggressive implications (eliminating them, exaggerating them, etc.) is revealing of him, it seems desirable that an alternate story be constructed so as to take this into consideration. An alternate story is indispensable for retests.

4. The Similarities-Differences Test has at present only passing and failing criteria and no half scores. Our data show that verbal concept-formation has several levels of development and impairment, the discrimination of which is diagnostically useful. If a revision of scoring is not feasible, norms for responses of intermediate frequency would be useful for the purpose of diagnostic appraisal.

5. The Cube Construction Test with which we have indirect familiarity from the Cornell-Coxe Performance Scale is, from the clinical point of view, a singularly uninstructive test; replacing it with a test of visual organization or visual anticipation like a Picture Arrangement or a Picture Completion Test would round out the present test to a superior clinical tool.

(c) MINOR SUGGESTIONS AS TO ADMINISTRATION

1. It is suggested that in the Story Recall Test, a verbatim recording of the subject's recall be made because the manner of verbalization, organization, sequence and distortion in recall are important guides in clinical diagnostic work.

2. It is recommended that an additional record blank be provided for the recording of qualitative observations of performance.

3. It is recommended that none of the tests be terminated at a time when, from the point of view of the scoring, the test has to be considered failed, but rather that the tests be further pursued in order to evaluate whether or not certain failures have been brought about by temporary inefficiency of the subject or by fundamental impairment. This consideration applies especially to the Shoulder Patches Test.

(d) GENERAL RECOMMENDATIONS

1. It is recommended that a set of equated scores for all the subtests be developed so that the scores on each will be directly comparable to the scores on the others. It is preferable that the range of the weighted score scale be near or slightly above 20 units. It is recommended that there be provided on the record blank, space for a scattergram or score-profile which would allow for a visual representation and assessment of the relationship of the equated scores on the different subtests.

2. It is recommended that the Vocabulary Test which has been standardized in the course of developing this test be added to the tests and that an equated score for the Vocabulary Test be provided. It does not, however, seem necessary to include the Vocabulary Test among those from which the total intelligence score is computed.

3. It is recommended that a Delayed Recall Test for Story Recall be introduced, either replacing the set of questions about the story, or supplementing the test in the same manner suggested for the Vocabulary Test.

4. It is recommended that the Cube Construction Test, if possible, be eliminated and replaced by a Picture Arrangement Test of visual anticipation or a Picture Completion Test of visual concentration.

With the recommended improvements the test's assets will more clearly come to the fore and its clinical diagnostic value will be unquestionable. It can be justly hoped that then it will not only provide the clinical psychologist working in the Armed Forces with a useful tool but also that it will become one of the prominent tools of the clinical psychologist in postwar practice and research.

BOOK NOTICES

From Gods to Dictators. By PRYNS HOPKINS. Price $1.65. Pp. 168. Girard, Kansas, Haldeman-Julius Publications, 1944.

Beyond the basic goals of food, security and reproduction the author finds the real goal of human beings to be the greatest lasting happiness of the greatest number, attainment of which requires a long, strict learning period. He gauges by modern psychological knowledge, particularly psychoanalysis, how the great religions—Egyptian, Jewish, Greek, Buddhistic, Christian and Mohammedan—and their modern political substitutes—communism, fascism and nazism—have succeeded or failed in increasing human well-being. For example, certain rituals designed to satisfy psychological needs have often served destructive purposes: the necessary principle of sacrifice permits cult followers to unload guilt feelings upon a scapegoat, but may result in death or mutilation of an object; the religious device of confession, though of great cathartic value usually reenforces harmful repressions. Such aberrant practices have led to periods of great violence, despite religious teachings against violence. This study indicates scholarly research and careful correlation of religious and scientific concepts. (B. S. E.)

Family Situations. An Introduction to the Study of Child Behavior. By JAMES H. S. BOSSARD AND ELEANOR BOLL. Price $3.00. Pp. 265. Philadelphia, University of Pennsylvania Press, 1943.

The title of this book gives no clear clue to its content. The main thesis of the authors is that the scientific study of behavior from the standpoint of environment (referred to as the "situational approach") is a separate field for scientific investigation from the study of the personality. They also believe that sociology is the appropriate science to undertake the analysis of social situations in general and of family situations in particular. They discuss the problem of finding a distinctive field for the sociologist, asking, "Where does sociology fit into the social science field, especially in relation to other sciences which deal with human phenomena? What is its distinctive material?" and answer these questions by saying, "Let the biologists, psychologists, psychiatrists and psychoanalysts study the individual's behavior: it is the sociologist who studies the social situations to which they react."

The authors have made a classification of family situations derived from a survey of the available literature on family life for the years 1926 to 1940. They urge sociologists to describe patterns of family life and culture objectively with a minimum of interpretation. (J. L. M.)

Goals and Desires of Man. By PAUL SCHILDER. Price $4.00. Pp. 305. New York, Columbia University Press, 1942.

This collection of essays is very representative of Schilder. At his best he had brilliant ideas, penetrative insight, broad erudition and a catholic attitude toward psychological science. His fault lay in a tendency to leave many trends of thought incompleted so that flashes of scientific inspiration are scattered amidst much that is less valuable. The chapter

on work, for example, begins with some inspiring major chords but peters out in thumbnail sketches of the lives of three historical characters in none of which are the motives of the work impulse analyzed or even discussed. In spite of this, every psychiatrist should read this book for its stimulating effect. (K. A. M.)

Interviewing: Its Principles and Methods. By ANNETTE GARRETT. Price $1.00. Pp. 123. New York, Family Welfare Assn. of America, 1942.

The associate director of the Smith College School for Social Work presents in this excellent manual a few of the elementary principles of conducting an interview. She cites nine illustrations of skillfully managed interviews and adds a brief recapitulation which says in substance that the interviewer should begin where the client is, gradually get across to him what help is offered and what responsibility the client himself must assume, then focus the interview on the territory most likely to be fruitful and cultivate the confidence of the client and avoid mere passive listening which "leaves the client floundering in the sea of uncertainty." The interview should then be closed by tying together the threads and restating the plans of both interviewer and client. One of the most important skills for an interviewer is a knowledge of his own limitations. (K. A. M.)